DOCUMENT RESUME

ED 179 885 CG 014 030

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TITLE Psychological Consultation in an HMC Hospice.
PUB DATE 1 Sep 79
NOTE 9p.; Paper presented at the Annual Convention of the American Psychological Association (87th, New York, NY, September 1-5, 1979)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Consultants; *Consultation Programs; Coping; *Counselor Role; *Hospital Personnel; Hospitals; Inservice Education; Medical Services; *Psychological Services; *Psychologists; *Staff Improvement; Therapists
IDENTIFIERS *Hospices

ABSTRACT

Hospice care differs from traditional medical care in that it aims to optimize the quality of the patient's remaining life rather than to maximize its duration. The Hayward Hospice project, begun in November of 1977 as a pilot project to evaluate whether hospice quality care could be provided within manageable costs and thus be included as a health plan benefit, is presented. Several features are described such as the unique location within an acute care medical facility, patient referrals by any of the staff physicians, and high acceptance by patient, family, and physician. Psychological consultation with the Hayward Hospice project is described, focusing on requests for evaluation and differential diagnosis, staff inservice education programs, and strategies for helping staff members cope and maintain their morale under the stress of providing services for terminally ill individuals. (Author)

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PSYCHOLOGICAL CONSULTATION IN AN HMO HOSPICE[1]

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I

HOSPICE IN CURRENT HEALTH CARE

"Hospice" was a medieval term used to refer to a place designated to provide comfort and hospitality to travellers. In the present sense it refers to a place, really a concept or philosophy, for a kind of care for terminally ill patients. It aims to maximize quality rather than length of life when the disease, usually cancer, is past the stage of treatment other than palliation. Hospice philosophy agrees with Aretaeus, who noted around 200 A.D. that,

> "It is impossible to make all the sick well, for the physician in that case would be superior to the Gods: but the physician can secure respite from pain." (Aries, 1974).

Hospice care typically requires cessation of aggressive, often uncomfortable, procedures such as, radiation, chemotherapy and most surgery and intubation. Palliative strategies are used instead. These aim to control pain, nausea, insomnia, etc. The goal is to enable patients to remain comfortable and alert during their last days. There is also an attempt to control anxiety and depression and to minister to spiritual needs. Finally, hospice care usually treats patients and their families as a unit.

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II

HAYWARD HOSPICE

The Kaiser-Permanente Hayward Hospice is a pilot project designed to investigate the following questions:

Can hospice care principles be adapted to an acute care hospital environment?

What are patients, family and medical staff responses to a hospice program in a prepayment health care system?

What are the identifiable costs and benefits?

Can hospice principles be extended to other areas of the hospital?

The goals of the project were summarized by the medical director as follows:

> "to determine for the Kaiser Health Plan Board of Directors whether or not hospice quality terminal care can be integrated within a Kaiser-Permanente medical center on a level satisfactory to Kaiser Foundation Health Plan members and Permanente Medical Group physicians, and at a reasonable cost" (Walter, 1979, p. 29 & 33).

Though modelled after the St. Christopher's Hospice in London, the Hayward Hospice project is nearly unique in that it is located within and fully integrated into an acute care general medical facility. It began operation on November 8, 1977, after about two years' planning.

Contrary to usual administrative resistance to novelty or change, Kaiser administration has endorsed trial projects and agreed to the following:

> to allow us to try to organize and integrate "service and place" utilization in a somewhat different fashion than what had been done traditionally
>
> to allow us to engage in trials of nurse/patient staffing ratios to determine the optimal mix
>
> to allow us to designate an area of the hospital which would be redecorated and refurnished in a home-like way for patients and families
>
> to allow us to remove all visiting restrictions
>
> to provide sleeping accommodations for relatives wishing to spend the night with the patient
>
> to make it possible for families to eat together when they wish to.

The Nursing Office agreed to the training of a core group of nurses and aides who wanted to work with the terminally ill and agreed to staff the Hospice inpatient unit from the core group whenever possible. Finally, the Home Care Program was expanded to provide services in patients' homes as well as visits to patients living in extended care facilities.

By way of an overview: we operate in an eight-bed (4 rooms) area of the hospital. We also have an office for the coordinator, a meeting room, and a pleasantly furnished family room. Nurses and volunteers are selected and trained for Hospice care and our staff to patient ratio is higher than most other units.

We emphasize home care. At any given time about 70% to 80% of our patients are treated at home with aid provided by our home care team. Family members are shown how to perform necessary procedures, e.g., administration of oxygen, placing or turning the patient in bed, giving pain medication, etc. Inpatient care is available when needed to provide some respite for the family or for special patient needs.

Any staff physician may place an appropriate patient in Hospice. In general, these are patients for whom aggressive treatment is no longer effective, whose life expectancy is 6 months or less, and who can accept substitution of palliation in place of aggressive treatment. We also require some family member or friend to be available to serve as the "primary caring person" for the patient's care at home. The procedure is for the patient's physician to propose the patient for admission to Hospice to one of our six "admitting physicians". If the case is judged to be appropriate, the patient is admitted into the Hospice program. The patient's own physician continues to treat him., thus providing continuity of care. If his or her R_x methods clash with Hospice methods, we use the oppor-

tunity for mutual education of the patient's physician and Hospice staff, all the while protecting the doctor/patient relationship.

To some degree instituting our Hospice was an exercise in social engineering. It was necessary to secure acceptance of Hospice methods from at least three potentially reluctant sources: patients, their families and their physicians. With this is mind we defined these as the three populations we try to serve. So far this seems promising. Patient, family and physician acceptance as measured by their rate of use has been high. In 1978 an estimated 80% of the potentially appropriate patients were referred to us. We cared for 124 patients during 1978 with 70% to 80% of care occurring in the home. Favorable comments from patients, family members and treating physicians serve as an additional informal indicator of growing acceptance.

III

FUNCTIONS OF THE PSYCHOLOGIST

Our strategy at the Hayward Hospice is for the psychologist to serve in a consultative capacity. My clientele is primarily the staff; my direct patient care is infrequent and secondary. We use this strategy for several reasons. First of all, it is consistent with our philosophy (Walter, 1979, p. 79), following Saunders (1976), that there is little need for counseling let alone psychotherapy among hospice patients. They need practical care and the psychologist uses his psychological understanding to assist staff to respond to what patient needs really are. Our consultative strategy also increases the impact of my few hospice hours per week.

Why use a psychological consultant at all? I will try to show that psychologists

can offer unique contributions to hospices and that this is consistent with our rejection of a mental disease model of psychological distress in the dying.

One way to construe many requests for psychological consultation is as a request for evaluation or differential diagnosis. Even though we do not regard psychic distress in response to chronic pain and impending death as illness per se, it is certainly true that treatable psychiatric illness can occur in this population. I may thus be asked to distinguish between more or less normal, inevitable responses to the stress of terminal illness as distinguished from abnormal conditions which may respond to specific treatments, e.g., anti-depressant or anti-psychotic medication. Besides making this distinction I usually can suggest some management strategies including psychiatric consultation when needed.[1]

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[1]The notion of palliative psychological care presents some difficulty. Just as curative surgery, etc., is abandoned in favor of "comfort care", no attempt is made to modify patients' psychic structure. Patients are not subjected to the rigors of the usual psychotherapy relationship. However, palliation does not require gratification of neurotic wishes. Fantasy wishes probably are impossible to fulfil but the attempt to do so by staff may produce more rather than less distress. Here is an instance where a psychologically informed consultant can help care givers come to see what patients truly want and to respond to patients' real needs as best they can.

For instance, consider the case of patients who seem to want to inflict pain on their families or the staff, perhaps using their own pain as a weapon. Behaviorally such patients may act so demandingly and complainingly that caretakers feel they cannot endure it. Since such aggression, whether conscious as such or not, usually produces guilt when gratified, Comfort care is best served when caretakers protect themselves from such mistreatment. In palliative care the aggressive wish need not be interpreted. Caretakers gently but firmly decline to let patients mistreat them while remaining available to provide needed care.

Another related instance occurs with patients who want to regress and do so to the extent allowed by caretakers. However tempting, most patients suffer lowered self-esteem, humiliation, perhaps guilt or even resentment against caregivers who promote their regression. The psychological consultatant can help staff assess what patients can or cannot do for themselves and support their effort to help patients resist regressive trends.

Another side of my consultative function is to provide service to staff. One form of this is in-service educational programs, more or less formal presentations of useful information for hospice workers. Another service has to do with helping staff workers cope with the inevitable anxiety produced by mental illness in patients, as well as anxiety from working in the presence of pain and death.

Staff morale is another area for which I assume some responsibility. The work is difficult and often demoralizing. Terminal illness and chronic pain are severe stressors for staff as well as patients and their families. This stress contributes to transient reactive depressions, interstaff conflict, etc. As a kind of inside-outsider I am sometimes in a position to intervene in various ways.

How are the psychological consultant functions carried out? I spend one afternoon each week on the hospice inpatient unit during which time I am available for consultations regarding patient care, occasional visits with patient and/or their families, and to listen to various concerns of the staff. From time to time, I make additional time available for in-service programs or other programs in which I may be useful (e.g., all day staff discussion of death early this year). In a few cases I have seen patients or surviving family in more or less ordinary psychotherapy. And, of course, I am available on-call at all times.

One further point I consider worth noting is that the skills required for my Hospice work are common to most clinical psychologists. Once accustomed to the novelty of the hospice situation most experienced clinical psychologists would probably find hospice work only superficially different from most other clinical positions.

Following Lipowski (1974) I agree that a consultant has three areas of responsibility: clinical work, teaching and research. In future papers I plan to report

observations concerning dreams in the bereaved, physical health of bereaved under various conditions and comparative effectiveness of various interventions.

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